



2003

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### Recommended Citation

Sylvia A. Law, *Do We Still Need a Federal Patients' Bill of Rights?*, 3 YALE J. HEALTH POL'Y L. & ETHICS (2003).  
Available at: <https://digitalcommons.law.yale.edu/yjhple/vol3/iss1/1>

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## Do We Still Need a Federal Patients' Bill of Rights?

Sylvia A. Law, J.D.\*

Since 1997, proposals for a federal patients' bill of rights have enjoyed strong, bipartisan political support, from Congress,<sup>1</sup> presidential candidates,<sup>2</sup> and the two major political parties in their party platforms.<sup>3</sup> Despite widespread approval, nothing has been adopted, and, furthermore, nothing has even come close.<sup>4</sup> This Article examines developments in markets, state law, and federal court decisions that attest to the continued need for a federal patients' bill of rights.

Part I begins with a pair of narratives illustrating the deep-rooted problems that have generated the extraordinary consensus that federal legislation is needed to protect patients' rights. Part II briefly describes the application of the Employee Retirement Income Security Act of 1974 (ERISA) to disputes about health care coverage, highlighting the regulatory vacuum created by ERISA's preemption of state law and managed care's exacerbation of the resulting problems. Parts III and IV address two controversies plaguing proposals for a federal patients' bill of rights. First, while the Supreme Court, in *Pegram v. Herdrich*,<sup>5</sup> authorized some state remedies for the negligent medical decisions of ERISA plans, it

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<sup>1</sup> The most influential of the early bills was the Patient Access to Responsible Care Act (PARCA) introduced by Representative Charles Norwood (R-GA) in April 1997. H.R. 1415, 105th Cong. (1997). The legislation was co-sponsored by 230 House members and a parallel bill was introduced in the Senate. S. 644, 105th Cong. (1997).

<sup>2</sup> *The 2000 Campaign; Exchanges Between the Candidates in the Third Presidential Debate*, N.Y. TIMES, Oct. 18, 2000, at A26.

<sup>3</sup> See *The Democrats: The Party Program; Excerpts from Platform Approved by Democratic National Convention*, N.Y. TIMES, Aug. 16, 2000, at A26; *The Republicans; Excerpts from Platform Approved by Republican National Convention*, N.Y. TIMES, Aug. 1, 2000, at A16. While both parties share an abstract commitment to "patients' rights," they disagree on the details. See *infra* Part V.

<sup>4</sup> See *infra* Part V (discussing the details of the political battle over proposals for a federal patients' bill of rights).

<sup>5</sup> 530 U.S. 211 (2000) (discussing managed care liability for negligence).

provided little guidance on when managed care organizations (MCOs) are liable for unreasonable medical decisions that cause death or disability. Second, although the Supreme Court, in *Rush Prudential HMO, Inc. v. Moran*,<sup>6</sup> upheld some state programs for independent medical review of denials of recommended care, it left many people without access to such review. Part V describes two proposals for a federal patients' bill of rights, focusing on the two questions considered in Parts III and IV. The Article concludes that even though *Pegram* and *Moran* have significantly changed the shape of the law, we still need a federal patients' bill of rights. However, the legislation supported by the House leadership in the 107th Congress would diminish rather than expand patients' rights, and may be unnecessarily complex and unwisely disrespectful of the capacity of the states to address complex problems.<sup>7</sup>

## I. EXPERIENCE WITH MANAGED CARE HAS GENERATED SERIOUS CONCERN

This section frames the issues by presenting two recently litigated disputes between patients and MCOs—disputes of a sort that has become all-too-typical in the managed care arena.

Florence Corcoran's story<sup>8</sup> is often cited by advocates to demonstrate the need for a patients' bill of rights.<sup>9</sup> Corcoran, a long-time employee of South Central Bell Telephone Company, became pregnant in 1989. Her obstetrician, Dr. Jason Collins, recommended that she be hospitalized for the final months of her pregnancy. During Corcoran's first pregnancy, Collins had recommended the same course and, when the fetus went into distress, it was delivered by caesarean section. Collins communicated with the medical director of Bell explaining the factors that put Corcoran at

<sup>6</sup> 122 S.Ct. 2151 (2002) (discussing the preemption of state laws providing for independent review of managed care judgments of medical necessity).

<sup>7</sup> This Article, like the major provisions of the proposed federal patients' rights legislation, focuses on the processes whereby MCOs decide whether medical treatment is necessary and thus covered by insurance. In an ideal world, the concept of "patients' rights" would also encompass concern for the fourteen percent of the United States population that has no health insurance coverage. U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE: CURRENT POPULATION REPORTS 60-215 (2000), available at [www.census.gov/prod/2001pubs/p60-215.pdf](http://www.census.gov/prod/2001pubs/p60-215.pdf). In addition, a more sensible concept of patients' rights would address the alarmingly high rate of medical errors that result in countless injuries and in approximately 98,000 hospital deaths per year. L.T. KOHN ET AL., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 9 (Nat'l Acad. Press 2001).

<sup>8</sup> Corcoran v. United Healthcare, Inc., 965 F.2d 1321 (5th Cir. 1992), cert. denied, 506 U.S. 1033 (1992).

<sup>9</sup> See, e.g., Edward M. Kennedy, *The Urgent Need To Pass Real Patient Protections*, at <http://kenedy.senate.gov/~kenedy/statements/01/06/2001627405.html> (June 19, 2001).

risk. Bell's medical director sought a second opinion from another obstetrician who said that Collins' recommendation was sound and that "the company would be at considerable risk denying her doctor's recommendation."<sup>10</sup> Bell rejected the advice and denied approval for hospitalization. Corcoran stayed at home, attended a few hours a day by a visiting nurse. While the nurse was not present, the fetus went into distress and died.

The experiences of Basile Pappas<sup>11</sup> exemplify another common problem. Pappas was admitted to a community hospital emergency room at 11 a.m. complaining of paralysis and numbness in his arms and legs. The emergency room doctor, a neurologist, and a neurosurgeon all agreed that he needed emergency surgery that their small hospital was unable to provide. The doctors arranged to transfer him to Jefferson University Hospital. At 12:40 p.m., as Pappas was about to leave by ambulance, his MCO notified the doctors that he should be transferred to another university hospital that participated in his insurance plan. After lengthy negotiations, the doctors persuaded the second hospital to accept him. He was transferred at 3:30 p.m. As a consequence of the delay, Pappas suffered permanent quadriplegia.

## II. ERISA'S VACUUM: LIMITED FEDERAL REMEDIES AND THE PREEMPTION OF STATE REMEDIES

The very problems that Congress seeks to address were created by Congress, with the help of the Supreme Court, through ERISA.<sup>12</sup> Traditionally, states regulated insurance, including health insurance, through legislation, administrative oversight, and the common law of torts and contracts.<sup>13</sup> States also regulated medical care through the licensing of doctors, hospitals, and other health care providers.<sup>14</sup> They defined what is unreasonably negligent behavior through common law and statutes.<sup>15</sup> These bodies of state law are complex and take divergent approaches to common problems.<sup>16</sup>

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<sup>10</sup> 965 F.2d at 1322.

<sup>11</sup> *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001), *cert. denied sub nom.* U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co., 122 S.Ct. 2618 (2002).

<sup>12</sup> 29 U.S.C. §§ 1001 *et seq.* (2002).

<sup>13</sup> R. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 139-59 (1997).

<sup>14</sup> *Id.* at 967-74.

<sup>15</sup> *Id.* at 842-90.

<sup>16</sup> Sylvia A. Law & Barry Ensminger, *Negotiating Physicians' Fees: Individual Patients or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1, 57-63 (1986) (describing the diversity of state approaches to issues of health care access, quality, and costs).

ERISA was adopted to address the plight of workers denied of expected pension benefits.<sup>17</sup> Its central provisions require that employer-sponsored pension plans meet substantive federal standards regulating funding, participation, vesting, benefit accrual, and disclosure of information.<sup>18</sup> ERISA also deals with employee welfare benefit plans, including employer-sponsored health insurance. ERISA preempts state laws that “relate to” employee benefit plans. But rather than providing more protective federal rules as it does for pension plans, ERISA provides little federal regulation of welfare plans, creating a regulatory vacuum. In the late 1980s and throughout the 1990s, the Supreme Court grappled with the scope of ERISA’s preemption.

#### A. Section 514

ERISA’s explicit preemption clause—section 514—provides that ERISA “shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . .”<sup>19</sup> This broad federal preemption is modified by a savings clause that provides that nothing in ERISA “shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.”<sup>20</sup> This exemption allows states to regulate health insurance. When an employee benefit plan purchases health insurance for its members, it may be subject to state insurance regulation. However, when an employee benefit plan “self-insures,” it may not be subject to state regulation. This complex distinction is explored below.<sup>21</sup>

#### B. Section 502

ERISA’s second preemption of state law is not expressed but implied. Section 502(a) of the Act allows a plan participant or beneficiary to bring a civil action “to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan,” or for breach of fiduciary duty.<sup>22</sup> In 1987, in *Pilot Life Insurance Co. v. Dedeaux*,<sup>23</sup> the plaintiff alleged

<sup>17</sup> 29 U.S.C. § 1001(a) (2002).

<sup>18</sup> *Id.* § 1002(1).

<sup>19</sup> *Id.* § 1144(a). “State laws” includes “all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.” *Id.* § 1144(c)(1).

<sup>20</sup> *Id.* § 1144(b)(2)(A).

<sup>21</sup> See *infra* text accompanying notes 132-37.

<sup>22</sup> 29 U.S.C. § 1132(a)(1)(B) (2002).

<sup>23</sup> 481 U.S. 41 (1987).

that his insurance company had willfully refused to pay the disability benefits promised by the policy. He invoked Mississippi's tort remedy for willful refusal to settle contract claims, seeking redress for the injuries that had resulted. The Supreme Court, in an opinion by Justice O'Connor, held that ERISA preempted the claim for two reasons. First, the Mississippi tort remedy for willful refusal to settle contract disputes was not limited to insurance claims, and hence could not be saved as a form of insurance regulation.<sup>24</sup> Second, "the civil enforcement provisions of ERISA § 502(a) [are] the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits. . . ."<sup>25</sup>

Further, even though section 502(a) provides that a plan beneficiary may bring suit "to obtain other appropriate equitable relief" to "redress such violations" or to "enforce . . . the terms of the plan" or the provisions of ERISA, federal courts have held that this does not authorize people like Corcoran or Pappas to seek extra-contractual damages when medically necessary services are denied and injury results.<sup>26</sup> Finally, and most importantly, in 1989, in *Firestone Tire & Rubber Co. v. Bruch*, the Supreme Court, again in an opinion by Justice O'Connor, interpreted ERISA to say that if a plan retains discretion to determine what benefits are covered, federal courts deciding claims under section 502 may reverse only if the claimant meets a very demanding standard—showing that the plan's actions were "arbitrary and capricious."<sup>27</sup>

The thick federal preemption of state law is not limited to "laws dealing with the subject matters covered by ERISA. . . ."<sup>28</sup> For example, states have long recognized that insurance companies sometimes deny beneficiaries of legitimate entitlements. In response, many states provide that when an insurance company willfully denies benefits, beneficiaries can recover consequential damages in addition to the contract payments that had wrongfully been denied.<sup>29</sup> However, the Supreme Court held that ERISA preempts state remedies for willful refusal to provide insurance coverage<sup>30</sup> and that federal law provides no remedy for even egregiously wrongful practices beyond payment of the benefits promised by the

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<sup>24</sup> *Id.* at 50.

<sup>25</sup> *Id.* at 52.

<sup>26</sup> *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1321, 1334-35, 1337-39 (5th Cir. 1992). Other circuit courts have followed this holding. ROSENBLATT ET AL., *supra* note 13, at 1016.

<sup>27</sup> 489 U.S. 101, 110-15 (1989).

<sup>28</sup> *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 98-99 (1983).

<sup>29</sup> ROSENBLATT ET AL., *supra* note 13, at 142-47.

<sup>30</sup> *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58, 63-66 (1987).

contract.<sup>31</sup>

### C. *The Rise of Managed Care*

The rise of managed care has aggravated the problems created by ERISA preemption. Until the 1980s most Americans with insurance had coverage that allowed them free choice of providers at the time of care and paid doctors and hospitals on a fairly open-ended fee-for-service or reasonable-cost basis.<sup>32</sup> To hold down costs, MCOs require prior authorization for many treatments, restrict access to specialists, limit the doctors and hospitals from whom plan participants may obtain care, provide doctors financial incentives to limit care, restrict coverage of prescription drugs, and impose other constraints on medical care.<sup>33</sup> Thus, the rise of managed care, together with ERISA's regulatory vacuum with respect to employer-sponsored health insurance, has left tens of thousands of Americans without legal redress for death or injury due to MCOs providing substandard care or wrongfully denying or delaying promised care.

Why would Congress prohibit states from applying ordinary common and statutory law to employment-based health insurance plans? Or, to put the question differently, if Congress preempts state authority, why doesn't Congress regulate these plans? The answer is simple: big business and big labor persuaded Congress that a state and federal regulatory vacuum would allow them to negotiate fairer and more effective medical insurance plans than what federal or state government would mandate.<sup>34</sup> In 2001, only 13.5% of wage and salary workers were union members.<sup>35</sup>

### III. *PEGRAM V. HERDRICH: WHEN ARE MANAGED CARE ORGANIZATIONS LIABLE FOR INJURIES CAUSED BY UNREASONABLY DELAYING OR DENYING TREATMENT?*

In 1995, a unanimous Supreme Court decision signaled an increased willingness to examine the sweep of ERISA's preemption. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*,<sup>36</sup> the

<sup>31</sup> See *infra* Part IV.

<sup>32</sup> See Law & Ensminger, *supra* note 16, at 12-14.

<sup>33</sup> See *Pegram v. Herdrich*, 530 U.S. 211, 218-19 (2000).

<sup>34</sup> See Marie Gottschalk, *The Missing Millions: Organized Labor, Business, and the Defeat of Clinton's Health Security Act*, 24 J. HEALTH POL., POL'Y & L. 489, 494-97 (1999).

<sup>35</sup> Press Release, Bureau of Labor Statistics, Union Members Summary, <http://www.bls.gov/news.release/union2.nr0.htm> (Jan. 17, 2002).

<sup>36</sup> 514 U.S. 645 (1995).

Court held that New York's comprehensive hospital rate regulation law did not "relate to" ERISA plans, even though the vast majority of plans affected were self-insured, employment-based insurance plans.<sup>37</sup> Since *Travelers*, the Supreme Court has narrowed the range of state laws that "relate to" an ERISA plan under section 514, broadening state authority to regulate.<sup>38</sup>

Throughout the 1990s, lower federal courts struggled to implement the Supreme Court's ambiguous message about remedies for plan members who suffer injury when medically necessary services are delayed or denied. Many courts initially read ERISA's preemption broadly, finding the weak contractual remedies provided under section 502 to be exclusive.<sup>39</sup> Other courts, motivated by sympathy for injured patients and the new understanding of ERISA triggered by the Supreme Court's functional, "common sense" approach to statutory interpretation in *Travelers*, construed ERISA to permit state actions for extra-contractual damages when medical decisions denying benefits resulted in death or disability.<sup>40</sup>

#### A. *Corcoran*

*Corcoran* is a poignant example of judicial willingness to read ERISA to deny remedies to injured patients. The Corcorans filed a wrongful death action in state court alleging that they had lost their baby because of the negligence of their insurer's utilization review program. ERISA allowed the insurer to remove the claim to federal court and to argue that federal law preempted the state tort claims. The Fifth Circuit accepted that argument, finding that the medical director's decision to deny coverage for hospitalization "related to" the administration of an ERISA plan.<sup>41</sup> Corcoran asserted that the decision to deny hospitalization was a medical decision, and that it should therefore be governed by state medical malpractice law. The insurer argued that the decision was merely one of

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<sup>37</sup> A unanimous Supreme Court found that in interpreting the "relate to" language "[w]e simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656.

<sup>38</sup> *E.g.*, *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.* 519 U.S. 316 (1997) (holding that ERISA does not "relate to" an ERISA apprenticeship program and hence California's prevailing wage statute was not preempted); *De Buono v. NYSA-ILA Medical & Clinical Servs. Fund*, 520 U.S. 806 (1997) (holding that a New York tax on gross receipts of health care facilities was not preempted by ERISA, as applied to labs owned by ERISA plans).

<sup>39</sup> See *infra* text accompanying notes 42-45.

<sup>40</sup> See *infra* text accompanying notes 46-57.

<sup>41</sup> *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1328-39 (5th Cir. 1992).



coverage under the plan and that, under the insurance contract, it had reserved broad discretion to make coverage decisions. The Fifth Circuit held that the utilization review program “makes medical decisions as part and parcel of its mandate to decide what benefits are available under the ... plan.”<sup>42</sup> The court read section 514 to save ERISA plans from inconsistent rules that might be imposed through state negligence law. Having characterized the decision as one involving what benefits are available under the plan, the Fifth Circuit held that Corcoran’s only remedy under section 502 was a federal injunction ordering the insurer to pay the owed benefits.<sup>43</sup> The court was unmoved by the fact that Corcoran was in the late stages of a difficult pregnancy and could obtain relief only by showing that the insurer’s actions were arbitrary and capricious. The court stated: “[T]he acknowledged absence of a remedy under ERISA’s civil enforcement scheme for medical malpractice committed in connection with a plan benefit determination does not alter our conclusion.”<sup>44</sup> From 1992 to 1995, most lower courts reached the same conclusions.<sup>45</sup>

### B. Dukes

In 1995, the Third Circuit, in *Dukes v. U.S. Healthcare, Inc.*,<sup>46</sup> diverged from this bleak assessment of the remedies available to ERISA plan members. Darryl Dukes’ MCO primary care physician wrote him a prescription for blood sugar studies at a participating hospital. For unknown reasons, the hospital refused to perform the tests. Dukes died within days from an extremely high blood sugar level that could have been treated had it been detected. Dukes’ widow sued in state court alleging malpractice by all treating professionals and imputing vicarious liability on the MCO. The MCO removed the case to federal court, which relied on *Corcoran* to dismiss the claims against the MCO.<sup>47</sup>

The Third Circuit reversed, holding that section 514’s preemption of claims that “relate to” employee benefit plans does not apply to state medical malpractice claims against an MCO. The Third Circuit noted that

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<sup>42</sup> *Id.* at 1332.

<sup>43</sup> *Id.* at 1334-35, 1337-39.

<sup>44</sup> *Id.* at 1333.

<sup>45</sup> ROSENBLATT ET AL., *supra* note 13, at 1016-18; *see, e.g.*, Kuhl v. Lincoln Nat’l Health Plan, 999 F.2d 298 (8th Cir. 1993), *cert. denied*, 510 U.S. 1045 (1994).

<sup>46</sup> 57 F.3d 350 (3d Cir. 1995), *cert. denied*, 516 U.S. 1008 (1995).

<sup>47</sup> *Dukes v. U.S. Health Care Sys., Inc.*, 848 F. Supp. 39, 42 (E.D. Pa. 1994). *See also* Spain v. Aetna Life Ins. Co., 11 F.3d 129 (9th Cir. 1993); Visconti v. U.S. Health Care, 857 F. Supp. 1097 (E.D. Pa. 1994).

“a suit ‘to recover benefits due . . . under [the] terms of the plan’ is concerned exclusively with whether or not the benefits due under the plan were actually provided. The statute simply says nothing about the quality of benefits received.”<sup>48</sup> The Third Circuit emphasized that Mrs. Dukes’ claim that the MCO negligently selected and monitored doctors and hospitals did not involve an attempt to define new rights under the terms of the plan. Instead, Dukes was attempting to assert preexisting rights under general state agency and tort law:

Inherent in the phrases “rights under the terms of the plan” and “benefits due . . . under the terms of [the] plan” is the notion that plan participants and beneficiaries will receive something to which they would not otherwise be entitled. But patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan.<sup>49</sup>

The Third Circuit noted that “HMOs (health maintenance organizations) play two roles, not just one” in connection with the medical treatment provided to a plan beneficiary.<sup>50</sup> On the one hand, HMOs function in an administrative capacity, determining eligibility for benefits.<sup>51</sup> Challenges to eligibility determinations or contract coverage may only be brought under section 502. On the other hand, HMOs play “their role as the arranger of the [plan beneficiary’s] medical treatment.”<sup>52</sup> When they “provide, arrange for, or supervise the doctors who provide the actual medical treatment for plan participants,” and plaintiffs allege that the care provided violated state malpractice standards, there is no “claim for benefits” and hence no preemption under section 502.<sup>53</sup> Nothing “in the legislative history, structure, or purpose of ERISA suggest[s] that Congress viewed § 502(a)(1)(B) as creating a remedy for a participant injured by medical malpractice.”<sup>54</sup>

In short, *Dukes* recognizes a distinction between disputes about “quantity of benefits” or “utilization review” on the one hand, and “quality of benefits” or “arranging for the provision of medical care” on the other.<sup>55</sup> Because section 502 only encompasses claims “to recover benefits due . . . under the terms of [the] plan,” it does not apply to complaints about the

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<sup>48</sup> 57 F.3d at 357 (ellipses and brackets in original).

<sup>49</sup> *Id.* at 358.

<sup>50</sup> *Id.* at 361.

<sup>51</sup> *Id.* at 360.

<sup>52</sup> *Id.* at 361.

<sup>53</sup> *Id.* at 360.

<sup>54</sup> *Id.* at 357.

<sup>55</sup> *Id.* at 358-60.

quality of services actually provided. Hence, state remedies are not preempted.<sup>56</sup> Since 1995, most courts have followed the *Dukes* approach.<sup>57</sup>

### C. Pegram

In 2000, the Supreme Court considered the same issues in a different context.<sup>58</sup> Cynthia Herdrich had employment-based health insurance with a physician-controlled MCO. Herdrich experienced acute abdominal pain and consulted her MCO doctor, Lori Pegram. Dr. Pegram found a six – to – eight-inch inflamed mass in Herdrich’s abdomen and ordered an ultrasound. Pegram decided that Herdrich could wait for eight days to have the test done at a MCO-controlled facility fifty miles away. While waiting for her test, Herdrich’s appendix burst, causing peritonitis.

Pegram was a co-owner of the MCO, and her compensation increased if she limited testing. Herdrich sued in state court, seeking to hold Pegram and the MCO liable for negligence and fraud. The MCO removed the action to federal court and argued that Herdrich’s claims were preempted by ERISA. In light of *Dukes* and its progeny, most plaintiff attorneys would have contended that the dispute was one about “quality of benefits” and the “arranging for the provision of medical care.” Herdrich’s lawyer, however, chose not to contest the removal to federal court. Rather, counsel formulated a claim for breach of fiduciary duty under ERISA section 502 based on the allegation that the MCO provided doctors financial incentives inconsistent with their responsibilities to patients. Herdrich sought to have the MCO profits returned to patients. The Seventh Circuit held that a federal claim for breach of fiduciary duty is cognizable “where physicians delay providing necessary treatment to, or withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses.”<sup>59</sup>

The Supreme Court reversed. Justice Souter, writing for a unanimous Court, observed that MCOs always “take steps to control costs,”<sup>60</sup> and that Congress has expressed a policy judgment favoring MCOs.<sup>61</sup> The Court found that ERISA plans are odd fiduciaries in that they always have conflicts between saving money and providing care.<sup>62</sup> Employers have wide

<sup>56</sup> *Id.* at 356.

<sup>57</sup> ROSENBLATT ET AL., *supra* note 13, at 1032-37, 640-57 (1997 & Supp. 2000-01).

<sup>58</sup> Pegram v. Herdrich, 530 U.S. 211 (2000).

<sup>59</sup> Herdrich v. Pegram, 154 F.3d 362, 373 (1998).

<sup>60</sup> Pegram v. Herdrich, 530 U.S. at 219.

<sup>61</sup> *Id.* at 233.

<sup>62</sup> “In every case charging breach of ERISA fiduciary duty, then, the threshold question is not whether the actions of some person employed to provide services under a plan

discretion to determine the content of the plan and those decisions are not fiduciary.<sup>63</sup> Citing *Dukes*, the Court recognized a distinction similar to that drawn by the Third Circuit:

[P]ure “eligibility decisions” turn on the plan’s coverage of a particular condition or medical procedure for its treatment. “Treatment decisions,” by contrast, are choices about how to go about diagnosing and treating a patient’s condition: given a patient’s constellation of symptoms, what is the appropriate medical response?<sup>64</sup>

The Court noted that eligibility and treatment decisions are often “inextricably mixed.”<sup>65</sup> Congress “did not intend . . . HMOs to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians.”<sup>66</sup> The Court concluded that “mixed treatment and eligibility decisions by HMO physicians are not fiduciary decisions under ERISA . . . .”<sup>67</sup>

While the Court rejected Herdrich’s effort to hold the MCO liable on a federal claim for breach of fiduciary duty, it ruled that ERISA would not preempt a state law claim for negligence, malpractice, and vicarious liability. The Court noted:

[T]he defense of any HMO [to a federal claim of breach of fiduciary duty] would be that its physician did not act out of financial interest but for good medical reasons, the plausibility of which would require reference to standards of reasonable and customary medical practice in like circumstances. That, of course, is the traditional standard of the common law. . . . Thus, for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians. What would be the value to the plan participant of having this kind of ERISA fiduciary action? *It would simply apply the law already available in state courts and federal diversity actions today.*<sup>68</sup>

It would come as news to Corcoran that ERISA did not preempt her

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adversely affected a plan beneficiary’s interest, but whether that person was acting as a fiduciary (that is, was performing a fiduciary function) when taking the action subject to complaint.” *Id.* at 226.

<sup>63</sup> *Id.* (citing *Lockheed Corp. v. Spink*, 517 U.S. 882, 887(1996)).

<sup>64</sup> *Id.* at 227.

<sup>65</sup> *Id.* at 229.

<sup>66</sup> *Id.* at 231.

<sup>67</sup> *Id.* at 211.

<sup>68</sup> *Id.* at 235 (emphasis added).

state negligence claim against her MCO for its mixed eligibility / medical-necessity decision. In denying Herdrich's federal claim for breach of fiduciary duty, the Court appears to affirm the availability of state negligence law to test the reasonableness of mixed medical and eligibility decisions made by ERISA plans. The Department of Labor (DOL), the federal agency responsible for enforcing section 502, reads *Pegram* as holding "that treatment decisions and mixed eligibility and treatment decisions by physician employees of an HMO are governed by state malpractice standards and not ERISA fiduciary standards."<sup>69</sup> Most academic commentators agree that *Pegram* allows state law to impose basic malpractice norms on MCO medical care decisions.<sup>70</sup>

#### D. The Importance of *Pegram*

Lower courts have disagreed over the implications of *Pegram* as well as whether particular MCO actions are fairly characterized as "eligibility decisions" or "treatment decisions." The Third Circuit, a pioneer in *Dukes*, found that an MCO doctor's refusal to hospitalize a depressed patient, who subsequently committed suicide, "falls on the standard of care, not the denial of benefits side of the line," and hence that the medical malpractice claim could proceed in state court.<sup>71</sup> Similarly, the Pennsylvania Supreme Court held that Pappas' claim that delayed approval of emergency surgery constituted a "mixed eligibility and treatment decision," the adverse

<sup>69</sup> Brief of Amici Curiae Department of Labor at 7, *U.S. Healthcare Sys. of Pa., Inc. v. Pa. Hosp. Ins. Co.*, 530 U.S. 1241 (2000) (No. 98-1836).

<sup>70</sup> Phyllis C. Borzi, *Pegram v. Herdrich: A Victory for HMOs or the Beginning of the End for ERISA Preemption?*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 161, 166 (2001) ("[T]he Court in *Pegram* appears to be ready to push even more types of decisions out of the ERISA ambit and into state courts by holding that HMO decisions requiring physician judgment, even those also involving coverage issues, are not covered by ERISA."); Timothy S. Jost, *Pegram v. Herdrich: The Supreme Court Confronts Managed Care*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 187, 191 (2001) ("[T]he decision strongly suggests that HMOs themselves are now liable in state court under state malpractice law for a host of decisions previously thought to be immunized by ERISA preemption."); Wendy K. Mariner, *Slouching Toward Managed Care Liability: Reflections on Doctrinal Boundaries, Paradigm Shifts, and Incremental Reform*, 29 J. L. MED. & ETHICS 253 (2001) (arguing for a "personal medical information" standard that asks: "To make this decision, does the MCO need to know personal medical information about the individual patient? If the answer is yes, the decision is about the quality of care that the individual patient should have. If the answer is no, then the decision is a benefit coverage decision."). But see Louis Saccoccio, *Pegram's Significance for Managed Health Care*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 195, 200 (2001) ("[*Pegram*] does not mean a shift in how the federal courts should analyze ERISA preemption questions relating to HMO medical-necessity decisions. . . . [I]t did not hold that HMO coverage decisions involving medical-necessity issues are subject to state medical malpractice law.").

<sup>71</sup> *Lazorko v. Pa. Hosp.*, 237 F.3d 242, 250 (3d Cir. 2000).

consequences of which are properly redressed through state medical malpractice law.<sup>72</sup>

By contrast, in *Pryzbowski v. U.S. Healthcare, Inc.*,<sup>73</sup> the Third Circuit held that delayed referral to a specialist recommended by treating doctors was a decision about plan coverage, rather than quality of care. As Wendy Mariner observes, "it is difficult to distinguish a decision to deny coverage of an out-of-network hospital, as in *Pappas*, from the decision to deny coverage of an out-of-network physician in *Pryzbowski*."<sup>74</sup> While Mariner makes a telling point, the Third Circuit offered one possible ground for distinction. It noted that Pryzbowski's dispute with her MCO extended over seven months and "could have been the subject of a civil enforcement action under § 502(a)."<sup>75</sup> A savvy patient in Pryzbowski's situation might have concluded that such delay justified hiring a lawyer and seeking injunctive relief in federal court.<sup>76</sup> Certainly, it is more reasonable to tell Pryzbowski that she should have sought an injunction than to tell that to Pappas, whose emergency was measured in minutes and hours, not weeks and months. Nonetheless, as Part IV explains, for reasons of both process and substance, it is highly unlikely that a federal court would have provided Pryzbowski an effective remedy against MCO delay under section 502.

The Fifth Circuit, author of *Corcoran*, has construed *Pegram* even more narrowly. In response to *Corcoran* and similar cases, Texas had adopted a patients' bill of rights that included a right to prompt, independent review of MCO judgments of medical necessity. Following *Pegram*, the Fifth Circuit rejected Texas' argument that independent review was designed solely to assure that medical care met minimal malpractice standards.<sup>77</sup> In cases seeking redress for injuries caused by allegedly negligent MCO decisions denying coverage for necessary treatment, lower courts in the Fifth Circuit have insisted that, despite *Pegram*, *Corcoran* remains binding law and hence preempts such state medical malpractice claims against MCOs.<sup>78</sup>

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<sup>72</sup> *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001). See *infra* text accompanying note 88.

<sup>73</sup> 245 F.3d 266 (3d Cir. 2001).

<sup>74</sup> Mariner, *supra* note 70, at 265.

<sup>75</sup> 245 F.3d at 273.

<sup>76</sup> *Id.* at 273-74.

<sup>77</sup> *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 220 F.3d 641 (5th Cir. 2000).

<sup>78</sup> See *Tran v. Kaiser Found. Health Plan*, No. 3:00-CV-1559-P, 2001 U.S. Dist. LEXIS 14039 (D. Tex. Sept. 7, 2001); *Calad v. CIGNA Healthcare of Tex.*, No. 3:00-CV-2693-H, 2001 U.S. Dist. LEXIS 8538 (D. Tex. June 20, 2001).

*E. Managed Care and State Liability Rules*

For aggrieved patients, the question of ERISA preemption is only the first step.<sup>79</sup> Even if ERISA does not preempt compensation for their injuries, complex questions remain. *Pegram* holds that plaintiffs are entitled to the remedies offered by “the law already available in state courts.”<sup>80</sup> When a person or organization causes injury, state common law and statutes ordinarily determine whether compensation is available. Recovery depends upon substantive liability principles, procedural rules, evidentiary standards, limits on damages, the ability to find a lawyer, the attitudes of judges and juries, and other factors—all of which vary by state.

One point is clear, however. Even in the context of ERISA plans and managed care, doctors may be liable for medical malpractice if they do not meet professional norms. Corcoran could have sued Collins for not keeping her in the hospital despite the MCO’s determination that the bill would not be paid, even though Collins struggled on her behalf against the MCO.<sup>81</sup> Indeed, Pappas recovered damages against the doctors who did their best to get him emergency treatment that they themselves were unable to provide.<sup>82</sup> In short, if a doctor violates professional medical standards, he or she can be held liable, even if the MCO refuses to cover the recommended care.<sup>83</sup> “Medical malpractice plaintiffs need only show

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<sup>79</sup> Curiously, while the Third and Fifth Circuits have grappled with whether *Pegram* allows state law negligence claims against MCOs that delay or deny medically necessary treatment, there are few cases in other circuits. Given the millions of people insured through ERISA plans, and the frequency of contestable judgments of medical necessity, this lack of legal activity is hard to understand. For cases supporting state liability, see *Isaac v. Seabury & Smith*, No. IPO1-1437B/S, 2002 U.S. Dist. LEXIS 12413 (S. D. Ind. July 5, 2002) (holding that after *Pegram*, a complaint alleging negligence in making a medical-necessity determination is not completely preempted by ERISA and that state courts should decide whether the defendant was negligent and whether the state cause of action conflicts with ERISA) and *Rivers v. Health Options Connect, Inc.*, 96 F. Supp. 2d 1370 (S.D. Fla. 2000) (holding that after *Dukes*, a well-pleaded complaint alleging negligence in a medical-necessity determination is not removable to federal court). For a case supporting ERISA preemption, see *Cicio v. Vytra Healthcare*, 208 F. Supp. 2d 288 (E.D.N.Y. 2001) (holding that despite *Pegram*, state negligence claims challenging medical-necessity determinations are preempted by ERISA).

<sup>80</sup> 530 U.S. 211, 235 (2000) (emphasis added).

<sup>81</sup> *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992).

<sup>82</sup> *Pappas v. Asbel*, 724 A.2d 889, 889-91 (Pa. 1998), *rev’d on other grounds*, 768 A.2d 1089 (Pa. 2001).

<sup>83</sup> *Wickline v. State*, 239 Cal. Rptr. 810 (Cal. Ct. App. 1986), *petition for review dismissed*, 741 P.2d 613 (Cal. 1987). The patient’s doctor recommended extended hospitalization. When the insurer denied approval, the patient was discharged. Her condition worsened and her leg had to be amputated. The court rejected her negligence claim against the MCO. The court noted that “it was for the patient’s treating physician to decide the course of

that the deviation from the standard of medical care occurred; they are not required to show why it occurred.”<sup>84</sup> “A health care provider’s deviation from the standard of care is actionable whether it was occasioned by inadvertence, ignorance, mistake, superstition” or the MCO’s financial incentives for denial of coverage.<sup>85</sup>

While holding physicians liable for malpractice provides some protection to patients, concentrating liability on physicians is troublesome for several reasons.<sup>86</sup> First, many patients are understandably reluctant to sue the doctor who went the second and third mile attempting to persuade an MCO to approve appropriate treatment. Second, when MCOs create powerful financial and bureaucratic incentives encouraging doctors to refuse or delay care, it seems fundamentally unfair to immunize the MCO from liability if the incentives they create lead to unnecessary death and disability. Third, the standards for holding physicians liable for medical malpractice are, contrary to popular belief, highly demanding. A doctor can be liable only on the basis of expert testimony that the physician did something that no reasonable doctor would have done, and that the act or omission caused the plaintiff’s injury.<sup>87</sup>

If a doctor is an employee, then under ordinary principles of vicarious liability, the employer hospital or MCO can be held liable for the physician’s negligence.<sup>88</sup> However, most doctors are independent contractors, not employees, thus immunizing hospitals and MCOs from liability under conventional formulations of vicarious liability.<sup>89</sup> In the hospital context, many courts have relied on concepts of apparent or ostensible agency to hold hospitals vicariously liable, particularly where the doctor is selected by the hospital rather than the patient.<sup>90</sup> In the managed care context, since *Dukes*, virtually all courts, including the Fifth Circuit, have held that ERISA does not preempt claims seeking to hold an MCO

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treatment that was medically necessary to treat the ailment. . . . The decision to discharge is, therefore, the responsibility of the patient’s own treating doctor.” *Id.* at 819.

<sup>84</sup> *Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.*, 958 F. Supp. 1137, 1146 (E.D. Va. 1997).

<sup>85</sup> *Id.*

<sup>86</sup> The American Medical Association supports consumers in seeking ERISA reform, emphasizing patient protection and professional judgment. See Robert Pear, *Patients’ Rights Bill Revised in Bid for Passage in Senate*, N.Y. TIMES, Sept.13, 2000, at A21.

<sup>87</sup> ROSENBLATT ET AL., *supra* note13, at 844-78.

<sup>88</sup> *Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998) (holding that a hospital is vicariously liable for the negligence of physician employees), *rev’d on other grounds*, 768 A.2d 1089 (Pa. 2001); *Lancaster v. Kaiser Found. Health Plan of Mid-Atlantic States, Inc.*, 958 F. Supp. at 1146 (holding the same for MCOs).

<sup>89</sup> ROSENBLATT ET AL., *supra* note 13, at 921-27.

<sup>90</sup> *Id.*



vicariously liable for the negligence of its participating physicians.<sup>91</sup>

But, even if ERISA does not preempt vicarious liability claims, plaintiffs must show that a doctor can fairly be called an agent of an MCO. Most patients have little idea how physicians in their MCOs are selected. Thus, it is difficult to claim “ostensible agency” resting on the assertion that the patient assumed the MCO was exercising control over the selection and supervision of participating physicians. While early cases were divided,<sup>92</sup> more recent cases have held MCOs vicariously liable under the doctrine of “apparent authority” for the acts of their independent contractor physicians. For example, in 1999, the Illinois Supreme Court held an MCO liable for a specialist’s negligence under an apparent agency theory even though the plaintiff’s primary care doctor selected the specialist. “Plaintiff’s reliance upon . . . [the MCO] was inherent in . . . [the MCO’s] method of operation.”<sup>93</sup>

Another major question is whether MCOs can be held directly, or corporately, liable for constructing programs that are unreasonably likely to allow or encourage medical negligence. *Pegram* makes plain that managing care, including the use of financial incentives and utilization review to assure that care is necessary, is not per se unreasonable<sup>94</sup> and is not subject to federal challenge under section 502 as a violation of fiduciary obligations.<sup>95</sup> On the other hand, the Supreme Court has opened the door to the possibility that treatment decisions—choices about how to diagnose and treat a patient’s condition—and mixed eligibility / treatment decisions may be challenged under state negligence law.<sup>96</sup> Given this tension, it is difficult to know whether state tort remedies might nonetheless be preempted under section 514 “until some more precise definition is afforded to any duties being ascribed to . . . [ERISA plans] under state tort law.”<sup>97</sup>

Similarly, because ERISA has been broadly construed to preempt state

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<sup>91</sup> The Third, Fifth, Seventh, and Tenth Circuits have held that medical negligence claims against HMOs for vicarious liability are not within the scope of section 502(a) and, therefore, are not completely preempted because they involve conduct by the HMO in its capacity as provider and arranger of health services and not as plan administrator. *Id.* at 356; *see, e.g., Corporate Health Ins., Inc. v. Tex. Dep’t of Ins.*, 215 F.3d 526 (5th Cir. 2000), *reh’g and reh’g en banc denied*, 220 F.3d 641 (5th Cir. 2000); *Rice v. Paschal*, 65 F.3d 637, 646 (7th Cir. 1995); *Pacificare of Okla., Inc. v. Burrage*, 59 F.3d 151, 154-55 (10th Cir. 1995).

<sup>92</sup> ROSENBLATT ET AL., *supra* note 13, at 1037-45.

<sup>93</sup> *Petrovich v. Share Health Plan of Ill., Inc.*, 719 N.E.2d 756, 769 (Ill. 1999).

<sup>94</sup> 530 U.S. 211, 220-21 (2000). *See also, Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001) (Saylor, J., dissenting).

<sup>95</sup> 530 U.S. at 226.

<sup>96</sup> *Id.* at 232.

<sup>97</sup> *Pappas v. Asbel*, 768 A.2d at 1098 (Saylor, J., dissenting).

negligence claims asserting that MCOs unreasonably constructed programs to deny care, there is little law describing what is reasonable in the managed care context. Concern with costs is not, by itself, a mark of negligence. It is only when risk and severity of injury exceed the costs of precautions that the law concludes that a defendant's actions were unreasonable.<sup>98</sup> The notion that there are only two polar positions—complete freedom to impose utilization controls and financial incentives to deny care, or absolute prohibition of any consideration of cost—is foreign to the basic precepts of negligence law. Because of ERISA preemption, the nation is left with the formidable task of defining what constitutes “reasonable” cost-containment measures.

State courts have begun this task for MCOs that are not governed by ERISA.<sup>99</sup> For example, in 2000, the Illinois Supreme Court held that the doctrine of institutional or corporate negligence allowed Shawndale Jones to sue her MCO for institutional wrongdoing.<sup>100</sup> Jones could sue because she was insured through Medicaid and her claim was therefore not preempted by ERISA. The three-month-old plaintiff had become feverish, constipated, and fussy. After a long delay, her MCO-assigned doctor recommended castor oil over the telephone. Jones' condition deteriorated and her mother took her to an emergency room. Jones was diagnosed with bacterial meningitis and suffered serious permanent disability. Her MCO-assigned doctor served as the primary care physician for 4,500 patients, even though national professional standards provide that no more than 3,500 patients should be assigned to a single primary care physician. Furthermore, the MCO's promotional brochure promised that there would be one primary care physician for each 2,000 enrollees.<sup>101</sup> The court held that it is “reasonably foreseeable that assigning an excessive number of patients to a primary care physician could result in injury, as ... care may not be provided,”<sup>102</sup> and that imposing a duty on MCOs to maintain a safe physician-patient ratio would not prove overly burdensome.<sup>103</sup>

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<sup>98</sup> *United States v. Carroll Towing Co.*, 159 F.2d 169, 172 (2d Cir. 1947) (opinion by Hand, J.).

<sup>99</sup> ERISA does not apply to Medicare, Medicaid, and health plans organized for state and federal employees.

<sup>100</sup> *Jones v. Chicago HMO Ltd. of Ill.*, 730 N.E.2d 1119 (Ill. 2000).

<sup>101</sup> *Id.* at 1126.

<sup>102</sup> *Id.* at 1134.

<sup>103</sup> *Id.*

#### IV. *RUSH PRUDENTIAL HMO, INC. V. MORAN*: HOW CAN PEOPLE WITH INSURANCE ENFORCE THE RIGHTS TO WHICH THEY ARE ENTITLED UNDER THEIR INSURANCE CONTRACTS?

All of the remedies discussed previously are directed toward providing payment to injured patients or their decedents when medical care is unreasonably delayed or denied. Such damages, in addition to compensating for losses suffered, may also encourage MCOs to act more reasonably in designing cost-containment programs. However, preventing unnecessary deaths and injuries is far better than providing compensation after the fact. Patients and doctors have a powerful interest in a fair and expedient process to challenge ERISA plan decisions denying care recommended by treating physicians. For the Corcorans, after-the-fact money damages for the loss of their baby is surely a poor substitute for a review process that might have prevented their child's death.

ERISA offers two solutions. First, ERISA requires that plans provide all plan participants and beneficiaries opportunity for a "full and fair review" of adverse decisions on claims for benefits under covered plans.<sup>104</sup> Second, ERISA allows plan participants to sue in federal court to recover benefits due, or to obtain injunctive relief.<sup>105</sup>

In 2000, the Clinton administration DOL issued regulations strengthening the internal "full and fair" review of ERISA plans.<sup>106</sup> The rules require ERISA plans to (1) establish and disclose claims procedures, including the medical guidelines that plans consider; (2) issue decisions within ninety days from receipt of a claim, or seventy-two hours in the case of an urgent claim; and (3) avoid using any process, including filing fees, that "unduly inhibits or hampers" the initiation or processing of claims.<sup>107</sup> While the DOL recognized that independent external review is essential for ensuring rapid access to adequate medical care, it did not have the authority to compel such review. The DOL did suggest, however, that in the absence of a congressionally created federal external review process,

<sup>104</sup> 29 U.S.C. § 1133 (2002) (codifying ERISA section 503).

<sup>105</sup> See *supra* text accompanying note 26.

<sup>106</sup> 65 Fed. Reg. 70,246, 70,254 (Nov. 21, 2000), modifying 29 C.F.R. § 2560 (1998). These rules went into effect on January 1, 2001, and apply to all claims filed on or after January 1, 2002. The Bush Administration suspended all federal regulations issued in the last months of the Clinton Administration that did not take effect before January 20, 2001. See Memorandum of Andrew Card to All Executive Agencies, at [www.whitehouse.gov](http://www.whitehouse.gov) (last visited Nov. 20, 2002). Hence, the "full and fair" review regulations remain in effect.

<sup>107</sup> 65 Fed. Reg. 70,246, 70,266 (Nov. 21, 2000).

ERISA should not preempt state-based external review.<sup>108</sup> Since 1999, all but a few states have enacted laws providing independent professional review when doctors and insurance plans disagree over whether a particular treatment is medically necessary.<sup>109</sup> Circuit courts were split on whether ERISA preempts such laws.<sup>110</sup>

*A. Moran*

Last year, in *Rush Prudential HMO, Inc. v. Moran*, the Supreme Court resolved this circuit conflict, affirming state power to mandate independent review for MCOs that purchase insurance.<sup>111</sup> Justice Souter, who wrote for a unanimous Court in *Travelers*,<sup>112</sup> wrote for a five-to-four majority in *Moran*. Justice Thomas authored the dissent. All of the Justices agreed that state-mandated independent review requirements “relate to ERISA plans” and are thus preempted, unless saved as a form of insurance regulation.<sup>113</sup> All agreed that independent professional review requirements are a form of insurance regulation, at least with respect to plans that purchase insurance rather than self-insure.<sup>114</sup> The majority and dissent diverged on whether the independent review provisions are preempted because they “seek to supplant or add to the exclusive remedies in § 502.” Each relied on the Court’s 1987 decision in *Pilot Life Insurance Co. v. Dedeaux*<sup>115</sup> to support its position.

*Pilot Life* held that Mississippi’s common law tort action for bad faith

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<sup>108</sup> Brief of Amici Curiae Department of Labor, *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2002).

<sup>109</sup> *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151, 2178 (2002). This section relies upon PATRICIA BUTLER, KEY CHARACTERISTICS OF STATE MANAGED CARE ORGANIZATION LIABILITY LAWS: CURRENT STATUS AND EXPERIENCE (Kaiser Family Found. 2001); STEPHANIE LEWIS, A GUIDE TO THE FEDERAL PATIENTS’ BILL OF RIGHTS DEBATE 3 (Kaiser Family Found. 2001); KAREN POLITZ ET AL., ASSESSING STATE EXTERNAL REVIEW PROGRAMS AND THE EFFECTS OF PENDING FEDERAL PATIENTS’ RIGHTS’ LEGISLATION (Kaiser Family Found. 2002) [hereinafter KAISER PATIENTS’ RIGHTS 2002].

<sup>110</sup> Compare *Corporate Health Ins., Inc. v. Tex. Dep’t of Ins.*, 220 F.3d 641 (5th Cir. 2000) (holding that Texas’ requirement that MCOs submit disputes about medical necessity to an independent review organization is preempted by ERISA), with *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000) (holding that Illinois’ requirement that HMOs submit disputes about medical necessity to independent review is a form of insurance regulation that is saved from ERISA preemption).

<sup>111</sup> 122 S.Ct. 2151 (2002).

<sup>112</sup> 514 U.S. 645 (1995).

<sup>113</sup> 122 S.Ct. at 2154, 2178. The dissent agreed that state external review requirements regulate ERISA plans. *Id.* at 2175-76.

<sup>114</sup> *Id.* at 2163, 2177-78.

<sup>115</sup> 481 U.S. 41 (1987).

refusal to settle contract claims was preempted as applied to decisions made by ERISA plans. The Court based its conclusion on two independent grounds. First, it found that bad faith refusal to settle a claim was not limited to insurance companies and hence was not saved as state regulation of insurance.<sup>116</sup> This can be distinguished from the Illinois law considered in *Moran*, which solely targeted insurance. Second, the *Pilot Life* Court stated in dicta that Congress did not intend to allow the exclusive remedies of section 502 to “be supplemented or supplanted by varying state laws.”<sup>117</sup>

Relying on this dicta, the *Moran* dissent found that section 502 creates “an interlocking, interrelated, and interdependent remedial scheme” that represent a “‘careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans’” centered upon “‘the development of ‘a federal common law of rights and obligations.’”<sup>118</sup> For the dissent, the “interlocking, interrelated, and interdependent remedial scheme” mandated by Congress required only “full and fair” internal plan review—with no independent expert opinion—and federal court claims for contract benefits under a deferential standard that upholds discretionary plan decisions unless they are “arbitrary and capricious.”<sup>119</sup>

Thus, the dissent’s “federal common law of rights and obligations” under section 502 is a common law of enormous deference to the decisions of plan administrators.<sup>120</sup> Justice Souter found that such deference “overstates the rule expressed in *Pilot Life*.”<sup>121</sup> The majority acknowledged that there is some tension “between the congressional policies of exclusively federal remedies and the ‘reservation of the business of insurance to the States.’”<sup>122</sup> However, it found that the Illinois independent review requirements provide “no new cause of action under state law and authorizes no new form of ultimate relief. . . . [T]he relief ultimately available would still be what ERISA authorizes in a suit for

<sup>116</sup> *Id.* at 48-50.

<sup>117</sup> *Id.* at 56.

<sup>118</sup> 122 S.Ct. at 2172, 2174 (quoting *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. at 54, 56, and citing *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 146 (1985)).

<sup>119</sup> See *supra* note 27 and accompanying text.

<sup>120</sup> The cases in which federal courts reverse insurance plan medical-necessity determinations under section 502 are rare and involve egregious wrongdoing. See e.g., *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 58 (1st Cir. 1999) (reversing a plan decision rejecting the unanimous opinion of all the experts who examined the patient and the plan’s own guidelines); *Bedrick v. Travelers Ins. Co.*, 93 F.3d 149 (4th Cir. 1996) (same).

<sup>121</sup> 122 S.Ct. at 2166.

<sup>122</sup> *Id.* at 2165 (quoting *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. at 744).

benefits under" section 502.<sup>123</sup> The majority rejected *Firestone's* assumption that plans have absolute discretion to insist that federal courts review claims for benefits under section 502 using an "arbitrary and capricious" standard. Rather, it ruled:

Not only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly. [*Firestone* merely] held that a general or default rule of *de novo* review could be replaced by deferential review if the ERISA plan itself provided that the plan's benefit determinations were matters of high or unfettered discretion. Nothing in ERISA, however, requires that these kinds of decisions be so "discretionary" in the first place. . . . In this respect, [the Illinois independent review requirement] prohibits designing an insurance contract so as to accord unfettered discretion to the insurer to interpret the contract's term.<sup>124</sup>

As a consequence of *Moran*, people in states with independent review laws who have coverage through an insured ERISA plan have access to independent professional review of medical-necessity disputes between plans and treating physicians. Nonetheless, serious limitations remain on the remedies authorized by *Moran*.

### B. Independent Review and Timing

Questions of timing are important. Had they been in effect, would state requirements of independent external review have helped Florence Corcoran and Basile Pappas? Pappas probably would not have benefited. Many state programs and the proposals for a federal bill of rights require

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<sup>123</sup> 122 S.Ct. at 2167. The majority and dissent also disagreed in their characterizations of the remedy provided by the mandated independent professional review. The dissent asserted that the Illinois law "is . . . most precisely characterized as an arbitration-like mechanism to settle benefits disputes. . . . There is no question that arbitration constitutes an alternative remedy to litigation." *Id.* at 2175. The majority found that "[t]he Act does not give the independent reviewer a free-ranging power to construe contract terms, but instead, confines review to a single term: the phrase 'medically necessity,' used to define the services covered under the contract." *Id.* at 2168. Thus, the review process "does not resemble either contract interpretation or evidentiary litigation before a neutral arbiter, as much as it looks like a practice (having nothing to do with arbitration) of obtaining another medical opinion. The reference to an independent reviewer is similar to the submission to a second physician, which many health insurers are required by law to provide before denying coverage." *Id.* at 2169. The dissent replied that "while a second medical opinion is nothing more than that—an opinion—a determination under . . . [the Illinois law] is a conclusive determination with respect to the award of benefits." *Id.* at 2177.

<sup>124</sup> *Id.* at 2170.

decisions within seventy-two hours in emergencies.<sup>125</sup> While seventy-two hours is a tight limit for due process purposes, for patients seeking emergency care, three days is too long. In contrast, Corcoran might have obtained the recommended care given a seventy-two-hour time limit for urgent decisions. Even though her MCO was willing to reject the recommendations of all the experts it consulted, it is possible that a judgment by an independent, external reviewer would have carried more weight. In short, the remedies authorized by *Moran* best serve people who can pay for care out-of-pocket and then file a federal claim for contract benefits bolstered by independent reviewer determination that a treatment was medically necessary.

### C. The Self-Insurance Problem

Under *Moran*, state-mandated independent review is only available to people covered by plans that purchase insurance. State insurance regulations, saved from ERISA preemption, only protect beneficiaries in plans that are not “self-insured.”<sup>126</sup> In 1997, about one-third of the 150 million participants in private, employment-based plans nationwide received benefits through employer-sponsored, “self-insured” group health plans.<sup>127</sup>

To avoid state regulation, many plans that purchase insurance characterize themselves as “self-insured.” They accomplish this by buying “stop-loss” insurance to cover claims over a specified amount. Of course, if the “stop-loss” attachment point is sufficiently low, the employer is really just buying insurance, rather than providing a self-insured plan. In the early 1990s, the Maryland Insurance Commissioner issued rules requiring that, to be considered “stop-loss” insurance, the attachment point had to be at least \$10,000 per participant per year. In 1998, the Fourth Circuit held that the Maryland law was preempted by ERISA and was not saved by the insurance savings clause; the Supreme Court declined review.<sup>128</sup> The National Association of Insurance Commissioners has sought to develop ways of extending state insurance regulation to these “stop-loss” policies.<sup>129</sup>

<sup>125</sup> See references cited *supra* note 117 (state programs) and *infra* note 154 (federal bills).

<sup>126</sup> *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. at 732.

<sup>127</sup> Employee Benefit Research Institute, *Self-Funded ERISA Health Plans*, EBRI NOTES, June 1999, at 4. See, Troy Paredes, Note, *Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption*, 34 HARV. J. ON LEGIS. 233, 234 (1997).

<sup>128</sup> *Am. Med. Security, Inc. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997), *cert. denied*, 524 U.S. 936 (1998).

<sup>129</sup> Dan Lonkevich, *NAIC Revisits Regulating Stop-Loss Insurance Sold to Self-Insured Health Plans*, NAT'L UNDERWRITER, Oct. 5, 1998, at 54.

The Third, Fourth, Sixth, and Ninth Circuits have uniformly rejected these efforts.<sup>130</sup>

Thus, under the prevailing understanding of the difference between insured and self-insured plans under ERISA, it seems an employer who retains the first ten dollars of liability for employee health insurance can purchase stop-loss insurance and remain free of state insurance regulation under ERISA. From a policy standpoint, it is difficult to imagine why participants in insured ERISA plans are entitled to state-mandated independent review while participants in "self-insured" plans are not. Indeed, the Supreme Court, while recognizing this distinction, questioned its sensibility.<sup>131</sup>

#### *D. Bad Faith Refusal To Settle*

The tort of bad faith refusal to settle insurance claims is tremendously important to purchasers of insurance.<sup>132</sup> Without such a tort action, rational insurers can deny payments and hope that beneficiaries lack the ability or will to litigate. If the insurer guesses wrong, under traditional contract principles, it pays only the benefits due under the contract. It is no worse off than if it had paid the claim initially. In response to this problem, state courts recognized tort causes of action for bad faith refusal to settle insurance claims,<sup>133</sup> and most states adopted insurance regulations to provide such remedies.<sup>134</sup>

Some state legislatures and courts learned from Mississippi's experience and crafted remedies limited to insurance, reconciling their regulatory goals with ERISA's insurance savings clause.<sup>135</sup> In 1999, in *UNUM Life Insurance Co. of America v. Ward*, the Supreme Court found that California's "notice prejudice" rule is a form of insurance regulation and

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<sup>130</sup> See *Bill Gray Enters. v. Gourley*, 248 F.3d 206, 214 (3d Cir. 2001) (noting that there is a consensus among all four circuits that have decided whether stop-loss or excess insurance makes a "self-funded" employee benefit plan insured for the purpose of ERISA preemption).

<sup>131</sup> *Metro. Life Ins. Co.*, 471 U.S. at 747 ("Arguments as to the wisdom of these policy choices must be directed at Congress.").

<sup>132</sup> Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395 (1994).

<sup>133</sup> See, e.g., *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973).

<sup>134</sup> See Baker, *supra* note 132, at 1408.

<sup>135</sup> *Moran* affirms *Pilot Life's* holding that to be saved under the insurance savings clause, "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." 122 S.Ct. 2151, 2159 (2002).



hence not preempted by ERISA.<sup>136</sup> The rule stipulates that an insurance company's defense based on an enrollee's failure to give timely notice of a claim is not valid unless the company could show actual prejudice. Some courts have read *Ward* to allow state tort remedies for bad faith refusal to settle so long as a remedy is limited to insurance claims and insurance companies.<sup>137</sup>

However, courts remain divided as to whether ERISA's insurance savings clause saves a claim of bad faith refusal to settle.<sup>138</sup> *Moran* did not address bad faith refusal to settle. One way of reading the case stresses the importance of the point that independent review laws "provide[] no new cause of action under state law and authorizes no new form of ultimate relief." As *Moran* emphasizes, plaintiffs who use independent review can still only obtain contractual damages.<sup>139</sup> Tort remedies for bad faith refusal to settle could be viewed as a "new form of ultimate relief." On the other hand, even if section 502 provides the exclusive remedy for enforcing ERISA contracts, a tort action for bad faith refusal to settle could be seen as separate from the exclusive contract remedy. Alternatively, *Moran* could

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<sup>136</sup> 526 U.S. 358, 359 (1999). As a matter of common sense, a rule that by its very terms "is directed specifically at the insurance industry and is applicable only to insurance contracts" regulates insurance. *Id.* at 359. In addition, the "notice-prejudice" rule satisfied "all the criteria used to determine whether a state law regulates the 'business of insurance' within the meaning of the McCarran-Ferguson Act." *Id.* at 373. First, it "has the effect of transferring or spreading a policyholder's risk" by shifting "the risk of late notice and stale evidence from the insured to the insurance company." *Id.* at 374. Second, "the notice-prejudice rule serves as 'an integral part of the policy relationship between the insurer and the insured.' . . . California's rule changes the bargain between insurer and insured; it 'effectively creates a mandatory contract term' that requires the insurer to prove prejudice before enforcing a timeliness-of-claim provision." *Id.* Third, the rule was limited to entities in the insurance industry. *Id.* at 375. Finally "a state regulation [needn't] satisfy all three McCarran-Ferguson factors in order to 'regulate insurance' under ERISA's saving clause." *Id.* at 373.

<sup>137</sup> See, e.g., *Lewis v. Aetna U.S. Healthcare, Inc.*, 78 F. Supp. 2d 1202 (N.D. Okla. 1999) (holding that ERISA does not preempt common law torts for insurance bad faith); *Colligan v. UNAM Life Ins. Co. of Am.*, 2001 WL 533742 (D. Colo. Apr. 23, 2001) (same).

<sup>138</sup> Compare *Rosenbaum v. UNUM Life Ins. Co. of Am.*, No. CIV.A 01-6758, 2002 WL 1769899 (E.D. Pa. July 29, 2002) (holding that Pennsylvania's law on bad faith refusal to settle insurance claims is not preempted by ERISA as it falls under the insurance savings clause), with *Sprecher v. Aetna U.S. Healthcare, Inc.*, 2002 WL 1917711, at \*5, \*7 (E.D. Pa. July 19, 2002) (holding that Pennsylvania's law on bad faith refusal to settle insurance claims is preempted because it does not serve as "an integral part of the policy relationship between the insurer and the insured" and hence does not regulate insurance, and that "because Pennsylvania's bad faith statute provides a form of ultimate relief in a judicial forum that adds to the judicial remedies provided by ERISA, it is incompatible with ERISA's exclusive enforcement scheme and falls within *Pilot Life's* categorical preemption").

<sup>139</sup> 122 S.Ct. at 2167.

be construed as authorizing state insurance regulators to require a mandatory insurance term that says "if we, the insurance company, willfully and in bad faith refuse to settle a claim, we will compensate you for the injuries you suffered as a consequence of our bad faith."<sup>140</sup> As yet another alternative, a general state law creating remedies for any willful refusal to perform a contract could be seen as "not related" to an ERISA plan. Since *Travelers*, the "relate to" provision has been limited to laws targeted at ERISA plans.<sup>141</sup> A tort action for bad faith refusal to settle could be just another constraint in the panoply of generally applicable state laws with which ERISA plans, like everyone else, must comply.<sup>142</sup>

### *E. State Experience with Independent Review*

Few patients utilize state-mandated review programs. New York, which adopted an independent review program in 1999, has had the highest incidence of utilization. Between 1999 and 2000, 902 New York patients out of an estimated 8.4 million covered by the state's independent review

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<sup>140</sup> *McEvoy by Finn v. Group Health Coop. of Eau Claire*, 570 N.W.2d 397 (Wis. 1997), illustrates the operation of the common law tort of bad faith refusal to pay an insurance claim in the health insurance context. Thirteen-year-old Angela McEvoy suffered from anorexia nervosa, a potentially fatal eating disorder. As no one in her health plan had ever treated this condition, her doctors recommended that she be referred to a special clinic at the University of Minnesota. The HMO approved six weeks of treatment but no more, despite the recommendations of all treating doctors. The HMO urged the girl to join a newly formed in-plan outpatient group therapy session for compulsive overeaters. When her weight fell from ninety-six pounds to seventy-four pounds in two months, her mother took her back to the clinic and paid for her care out-of-pocket. Because McEvoy's mother was a state employee, her claim was not preempted by ERISA and she was able to bring a claim for extra-contractual damages and collect for the injuries she suffered.

<sup>141</sup> *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.* 519 U.S. 316 (1997).

<sup>142</sup> A tort remedy for bad faith refusal to pay a contract obligation might be characterized as "one of 'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute." *De-Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815 (1997). The Supreme Court further observed:

As we acknowledged in *Travelers*, there might be a state law whose economic effects, intentionally or otherwise, were so acute "as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers' and such a state law 'might indeed be preempted under § 514.' That is not the case here.

*Id.* at 816 n.16 (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 668 (1995)). The author has not been able to find a case in which an ERISA plan beneficiary has sought to invoke a general state law prohibiting bad faith refusal to settle contract claims, arguing that a general state law does not "relate to" an ERISA plan.

law sought review.<sup>143</sup> This means that 0.01% of eligible, privately insured New York patients have taken advantage of their right to independent review.<sup>144</sup> The experience in other states is similar, though even fewer patients sought review.<sup>145</sup> A 2001 national survey suggests that the number of patients who experience difficulty with health care plans is vastly larger than the number that seek independent review in states that allow it.<sup>146</sup> Furthermore, early evidence indicates that many claims presented for independent review have merit: "The rate at which independent reviewers overturn health plan denials ranged from a low of 21 percent in Arizona and Minnesota to a high of 72 percent in Connecticut, and averaged 45 percent across all states."<sup>147</sup>

The small number of patients who seek independent review, combined with the fact that independent review reverses plan decisions denying coverage in a relatively high number of cases, leads some consumer advocates to suggest that many state independent review programs create unjustifiable barriers.<sup>148</sup> One major factor limiting patient access to independent review is the requirement that patients exhaust internal complaint and appeals processes within their plans before seeking review.<sup>149</sup> In New York, health plans can require two or more internal appeals. That, combined with a brief window to file for review,<sup>150</sup> means that "consumers who remain in the plan system beyond the first appeal are likely to miss the filing deadline for external review and, thus, become

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<sup>143</sup> KAISER PATIENTS' RIGHTS 2002, *supra* note 109, at Exhibit A.

<sup>144</sup> *Id.* at vii.

<sup>145</sup> California reported 421 cases between 1999 and 2001. In Florida, 223 cases were filed between July 2000 and July 2001. In 2000, Texas had 404 cases, Arizona had 282, and Maryland had 255. In all other states, the volume of appeals was significantly smaller. *Id.* at Exhibit A.

<sup>146</sup> KAISER FAMILY FOUND. & HARVARD SCH. OF PUB. HEALTH, NATIONAL SURVEY ON CONSUMER EXPERIENCES WITH AND ATTITUDES TOWARD HEALTH PLANS, at <http://www.kff.org/content/2001/3172/ChartPack.pdf> (Aug. 29 2001). When asked if they have personally had any problems with their health plan in the past year, twenty-two percent of respondents cited problems with billing or payment for services, fourteen percent had problems with the plan not covering a particular treatment or service, seven percent reported delays in receiving care or treatment, and six percent said they had been denied care or treatment.

<sup>147</sup> KAISER PATIENTS' RIGHTS 2002, *supra* note 109, at v-vi.

<sup>148</sup> *Id.*

<sup>149</sup> Except for Missouri, every state that offers independent review requires exhaustion of internal plan remedies. *Id.* at 12, 14.

<sup>150</sup> Six states have no filing deadline. Twenty-four states have filing deadlines of thirty to sixty days. In Arizona, a patient has only five days from completion of the internal review process and receipt of the final notice of the denial to request an independent review. *Id.* at 13-14.

ineligible for this protection.”<sup>151</sup> On the one hand, it makes no sense to demand that patients pursue internal, possibly biased, review processes beyond the time during which they can seek independent view. On the other hand, it seems wise to allow plans to correct their own mistakes and to place some limit on when patients can invoke independent review. Striking the right balance between these competing considerations is difficult.

#### V. PATIENTS, DOCTORS, AND EMPLOYERS: WOULD THE TWO PROPOSALS FOR A FEDERAL PATIENTS' BILL OF RIGHTS HELP OR HURT?

The three most controversial provisions of the two proposals for a federal patients' bill of rights involve independent review of disputes between MCOs and treating physicians, the remedies available to patients who suffer injury or death when MCOs delay or deny recommended medical care, and the availability of extra-contractual damages when MCOs willfully refuse to settle legitimate claims.<sup>152</sup>

##### *A. Independent Review*

As a consequence of state legislation and the Supreme Court's decision in *Moran*, independent review is now available to patients enrolled in insured plans in all but eight states.<sup>153</sup> The bills supported respectively by the Senate and House leadership both require independent review of MCO decisions on medical necessity, demand its usage before filing suit,

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<sup>151</sup> *Id.* at 12.

<sup>152</sup> Many provisions in the proposed bill are not controversial and are supported by both the Senate and House. For example, both Houses would require that plans (1) provide information to enrollees about how they operate; (2) allow enrollees access to out-of-network specialists when a plan's network does not include an appropriate specialist; (3) pay for emergency care at the nearest hospital when a person reasonably believes that he or she is in distress; (4) provide coverage for mammography; and (5) allow people to use a pediatrician, obstetrician, or gynecologist as a primary health care provider. William G. Schiffbauer, *Analysis of Patients' Bill of Rights Legislation in the 107th Congress*, BNA's HEALTH CARE DAILY RPT. (July 16, 2001). Some of the problems targeted by such provisions have already been addressed in the marketplace, *Id.*, or through specific federal legislation. See e.g., Women's Health and Cancer Rights Act of 1988, 29 U.S.C. § 1185b (2002) [hereinafter WHCRA] (amending ERISA to require group health plans to provide coverage for "all stages of reconstruction of the breast on which the mastectomy has been performed"); Newborns' and Mothers' Health Protection Act, Pub. L. No. 104-204, §§ 601 *et seq.*, 110 Stat. 2874 (1996) (amending ERISA to prohibit plans from restricting hospital lengths of stay for "normal vaginal" deliveries to less than 48 hours). *Howard v. Coventry Health Care of Iowa, Inc.* held that neither WHCRA nor ERISA provides a private cause of action for a WHCRA violation. 293 F.2d 442 (8th Cir. 2002).

<sup>153</sup> See *infra* note 155.

and allow a federal cause of action under ERISA section 502 to provide contractual benefits deemed medically necessary by independent review.<sup>154</sup> Both bills extend these protections to patients in self-insured plans and to patients in the eight states without independent review programs,<sup>155</sup> imposing a uniform filing fee of up to \$25 for all claims.<sup>156</sup> Nonetheless, there are important differences between the Senate and House independent review proposals.

First, the Senate bill would establish minimum standards for independent review organizations, but would allow states to go further in assuring that external review was informed, unbiased, and fair.<sup>157</sup> The House bill would preempt state rules governing internal and external appeals for patients in “self-insured” ERISA plans, preserving the disparity between insured and self-insured plans.<sup>158</sup> Second, under the House bill, if independent review upholds a plan’s decision to deny a claim for benefits, the burden of proof falls on the patient to demonstrate through clear and convincing evidence that the plan did not exercise ordinary care in making its decision.<sup>159</sup> Under the Senate’s bill, states would be allowed to lower the burden of proof below a federal maximum; most states require claimants to show that it is more likely than not that the plan’s negligence caused the harm, that is, the traditional preponderance of the evidence standard.<sup>160</sup> Third, the Senate bill allows independent reviewers to “up[h{o}]ld, reverse[], or modif[y]” a benefit denial,<sup>161</sup> while the House rewrote its bill with the explicit purpose of denying independent reviewers the authority to modify a decision.<sup>162</sup> Experience with state independent review programs demonstrates that the reviewer’s ability to modify a MCO decision is

<sup>154</sup> S. 1052, 107th Cong. (2001); H.R. 2563, 107th Cong. (2001).

<sup>155</sup> The eight states that do not have independent review programs are Arkansas, Idaho, Mississippi, Nebraska, Nevada, North Dakota, South Dakota, and Wyoming. Linda Greenhouse, *Court, 5-4, Upholds Authority of States To Protect Patients*, N.Y. TIMES, June 21, 2002, at A1.

<sup>156</sup> S. 1052 § 104(b)(2)(A); H.R. 2563 § 503 (b)(2)(iv).

<sup>157</sup> S. 1052 § 401; LEWIS, *supra* note 109, at 6.

<sup>158</sup> H.R. 2563 § 152. *See also* BOSTON UNIV. SCH. OF PUB. HEALTH, PATIENT RIGHTS PROGRAM WHITE PAPER: DIFFERENT SYSTEMS OF LIABILITY TO PATIENTS 8, at <http://www.patient-rights.org/publications/pub0003.html> (Sept. 7, 2001).

<sup>159</sup> H.R. 2563 § 402(a) (adding new ERISA section 502(n)(1)(B)). *See also* LEWIS, *supra* note 109, at 8; BOSTON UNIV. SCH. OF PUB. HEALTH, *supra* note 158.

<sup>160</sup> LEWIS, *supra* note 109, at 6; BOSTON UNIV. SCH. OF PUB. HEALTH, *supra* note 158, at 10. In a few states, such as Georgia, state law creates a rebuttable presumption in favor of the health plan if it wins the external review decision. BUTLER, *supra* note 109, at 3.

<sup>161</sup> S. 1052 § 104(d)(3)(A).

<sup>162</sup> H.R. 2563 § 104 (adding new ERISA section 503(C)(h)(1)(B)). The word “modify” was expressly deleted from the bill by the Norwood Amendment. BOSTON UNIV. SCH. OF PUB. HEALTH, *supra* note 158, at 37.

important.<sup>163</sup>

In sum, the House version of independent review, far from protecting patients rights, may actually take them away, at least from those who have recently won protection under state laws and *Moran*. It strips independent reviewers of the power to modify plan decisions and makes it more difficult to enforce benefits claims in federal court. If states are allowed to pursue different approaches to independent review, ten years from now we are likely to know a lot more about what is fair and effective, both for patients and plans. Despite the Republicans' traditional embrace of states' rights, the House version of the bill would significantly limit state-sponsored independent review programs that seem to be working well. Governors across the country have expressed dismay that this would thwart state efforts to protect patients' rights.<sup>164</sup>

*B. Recovery of Damages for Unnecessary Death and Disability Caused by Negligent MCO Medical Decisions*

With regard to liability for MCO negligence in determining medical necessity, again the Senate and House bills have much in common. Both require exhaustion of internal remedies and independent review.<sup>165</sup> Both impose limits on non-economic and punitive damages.<sup>166</sup> In 2002, people

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<sup>163</sup> KAISER PATIENTS' RIGHTS 2002, *supra* note 109, at vi.

<sup>164</sup> Robert Pear, *States Dismayed by Federal Bills on Patient Rights*, N.Y. TIMES, Aug. 13, 2001, at A1.

<sup>165</sup> S. 1052 § 402(a)(n)(9); H.R. 2563 § 402(a)(n)(3)(A).

<sup>166</sup> Under the House bill, similar damages are provided for personal injury or death resulting from contract violation or medical malpractice. Successful plaintiffs may be awarded economic damages (e.g., medical expenses, lost wages) and non-economic damages (e.g., pain and suffering). H.R. 2563 § 402(a) (adding new ERISA section 502(n)(1)(A)). However, non-economic damages cannot exceed \$1.5 million. *Id.* (adding new ERISA section 502(n)(4)(A)). Punitive damages are permitted, also up to a limit of \$1.5 million, but only when a plan refuses to comply with the decision of an independent reviewer. *Id.* (adding new ERISA section 502(n)(4)(B)). Finally, the House bill permits states to limit non-economic and / or punitive damages to less than the \$1.5 million maximum. *Id.* (adding new ERISA § 502(n)(4)(C)).

The Senate bill distinguishes between claims based on contract violation and those based on medical negligence. In federal court actions for injuries resulting from contract violations, plaintiffs may recover compensatory economic and non-economic damages, without any cap. Punitive damages are not allowed. S. 1052 § 402(a) (adding new ERISA section 502(n)(1)). In state court actions based on medical decisions, damages remain a matter of state law, though states are not allowed to impose punitive damages unless the plaintiff shows by clear and convincing evidence that the health plan caused injury or death by acting with "willful or wanton disregard for the rights or safety of others." *Id.* (adding new ERISA section 514(d)(1)(C)). Finally, the Senate bill authorizes a federal action seeking civil penalties of up to \$5 million if the patient proves, by clear and convincing

who speak for Congress and the President asserted that the major stumbling block to enacting a federal patients' bill of rights is the limitation on damages.<sup>167</sup> The disputes about damages, while real, mask more fundamental questions about whether injured people can recover at all.

The House bill authorizes ERISA plan beneficiaries to sue if a designated plan decision-maker fails to exercise ordinary care in denying the claim for benefits or in failing to authorize coverage in compliance with the written determination of an independent medical reviewer.<sup>168</sup> If the plan fails to exercise ordinary care in *denying* coverage, and the patient suffers death or disability, the plan may be held liable for compensatory damages.<sup>169</sup> The House bill provides that this new cause of action can be brought in either federal or state courts, but ERISA provides the controlling substantive law.<sup>170</sup> Finally, and most significantly, the House requires a patient to demonstrate that the negligence in denying coverage was *the proximate cause* of the death or injury suffered.<sup>171</sup>

By contrast, the Senate bill draws a sharp distinction between "medically reviewable decisions" and decisions about coverage, eligibility, and cost sharing.<sup>172</sup> This distinction is similar to that articulated by *Dukes*, *Pegram*, and other cases. With respect to decisions about coverage, eligibility, and cost sharing that do not involve a medically reviewable

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evidence, that a health plan acted in "bad faith and flagrant disregard for the rights of the participant." *Id.* (adding new ERISA section 502(n)(10)(B)).

As a practical matter, the most important difference in terms of damages is that the House would limit non-economic damages to \$1.5 million, while the Senate would not. However, a majority of states impose limits on non-economic damages that may be awarded in malpractice cases. Mark D. Clore, *Medical Malpractice Death Actions: Understanding Caps, Stowers, and Credits*, 41 S. TEX. L. REV. 467, 471 (2000). Twenty-one states have a mandatory cap on damages in malpractice cases. *Id.* Some limit only non-economic damages; others limit either general or punitive damages. *Id.* Finally some states, such as Texas, limit all damages except for medical care and related expenses. *Id.* The Senate bill would allow states to apply their caps to claims challenging medically reviewable decisions. Malpractice caps have a seriously "disparate impact on patients who have suffered the most severe injuries from negligent treatment." Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 HARV. L. REV. 381, 405 (1994). Because of this unfairness, at least six state courts have found that medical malpractice damage limitations violate state constitutions. ROSENBLATT ET AL., *supra* note 13, at 910-11.

<sup>167</sup> Robert Pear, *White House and Senate Hit Impasse on Patients' Rights*, N.Y. TIMES, Aug. 2, 2002, at A1.

<sup>168</sup> H.R. 2563 § 402(a) (adding new ERISA section 502(n)(2)(F)).

<sup>169</sup> *Id.*

<sup>170</sup> *Id.*

<sup>171</sup> *Id.* (emphasis added).

<sup>172</sup> S. 1052 § 402(a)(1) (amending section 502 to add a new section (n)).

dispute, claims will remain in federal court, and federal standards will apply. Moreover, the current remedies under ERISA section 502 are modified to allow patients to recover economic and non-economic damages (but not exemplary or punitive damages) if the plan fails to exercise ordinary care and "such failure is a proximate cause of personal injury to, or the death of, the participant or beneficiary."<sup>173</sup>

For "medically reviewable decisions," the Senate bill modifies section 514's preemption of state laws to create a new savings clause stipulating that nothing in ERISA, including section 502, shall be construed to invalidate "any cause of action under State law of a participant or beneficiary under a group health plan . . . to recover damages resulting from personal injury or for wrongful death against any person if such cause of action arises by reason of a medically reviewable decision."<sup>174</sup> A "medically reviewable decision" is defined broadly to include denials based on "a determination that the item or service is not covered because it is not medically necessary and appropriate," "is experimental or investigational," or on any grounds "that require an evaluation of the medical facts by a health care professional in the specific case. . . ."<sup>175</sup> Further, "denial of claim for benefits" is defined broadly to include "a denial (in whole or part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits. . . ."<sup>176</sup> In short, the Senate bill basically follows the approach suggested by *Pegram*, allowing state courts to apply traditional malpractice norms to claims that unreasonable medical decisions by MCOs have contributed to death or disability.

### C. Remedies Against Insurers Who Willfully Refuse To Settle Legitimate Claims

Finally, the Senate bill allows federal courts to impose a "civil assessment" paid to the claimant if the claimant establishes by clear and convincing evidence that the plan "demonstrated bad faith and flagrant disregard for the rights" of the claimant and its decision was a proximate cause of personal injury or death.<sup>177</sup> This provision restores and federalizes the state tort of bad faith refusal to settle insurance claims that was preempted by the *Pilot Life's* interpretation of ERISA.<sup>178</sup> The House version has no comparable provision.

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<sup>173</sup> *Id.* (emphasis added).

<sup>174</sup> *Id.* § 402(d).

<sup>175</sup> *Id.* § 104(d)(2).

<sup>176</sup> *Id.* § 102(e)(3).

<sup>177</sup> *Id.* § 402(a)(10) (amending ERISA section 502 to add a new section (n)).

<sup>178</sup> 481 U.S. 41 (1987).



## CONCLUSION

As a general matter, apart from technical arguments of statutory interpretation, which have no purchase in the legislative context, ERISA plans oppose increased patient protections on two grounds. First, recognition of patients' rights might drive up insurance costs and hence discourage employers from offering health insurance. Second, to the extent that patients' rights are protected by allowing expanded state regulation, divergent state requirements hinder the ability of national insurance plans to administer uniform programs.<sup>179</sup>

With regard to economic ramifications, David M. Studdert and his colleagues conducted informal interviews with more than fifty senior MCO executives asking how the proposed bills might impact health care costs and access to coverage.<sup>180</sup> Many executives said that if the preemption of liability were lifted, they would keep better records.<sup>181</sup> Others stated that they might liberalize coverage determinations and make greater use of external review, even when it was not mandated.<sup>182</sup> Studdert's group therefore concluded that the direct costs of liability are uncertain.<sup>183</sup> Efforts to estimate costs are complicated by differences between the Senate and House versions, and by the fact that many provisions have already been adopted voluntarily or imposed through specific federal legislation.<sup>184</sup> Twenty-five percent of the privately insured population, or 35 million people—mostly government employees—are not covered by ERISA and already have most of the rights guaranteed by the most expansive versions of the federal patients' rights legislation.<sup>185</sup> Nevertheless, in 1998, the consulting group Coopers & Lybrand, L.L.P. investigated the litigation experience of this population and estimated that extending the federal patients' bill of rights to ERISA plan beneficiaries would add between three and thirteen cents a month to the cost of premiums.<sup>186</sup> Similarly, a

<sup>179</sup> See, e.g., Brief for Petitioner, *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2001) (No. 00-1021); Brief of Amici Curiae Am. Ass'n of Health Plans, Inc. et al., *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2001) (No. 00-1021).

<sup>180</sup> David M. Studdert et al., *Expanded Managed Care Liability: What Impact on Employer Coverage*, HEALTH AFF., Nov.-Dec. 1999, at 7.

<sup>181</sup> *Id.* at 9.

<sup>182</sup> *Id.* at 16.

<sup>183</sup> *Id.* at 24.

<sup>184</sup> See *supra* note 152.

<sup>185</sup> RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 137 (The Foundation Press 1997).

<sup>186</sup> COOPERS & LYBRAND, L.L.P., *IMPACT OF POTENTIAL CHANGES TO ERISA*, at <http://www.kff.org/content/archive/1415/erisa.html> (June 1998). The report was prepared for the Kaiser Family Foundation.

Congressional Budget Office (CBO) study the same year estimated that the cost of ending the ERISA preemption of state law would be 1.2% of premiums of all employer-sponsored plans, while a 2002 CBO study estimated that the liability provisions of the Senate bill would increase premiums by 0.8%.<sup>187</sup> Indeed, state experience with independent review, which shows that few patients take advantage of such evaluation,<sup>188</sup> suggests that independent review is unlikely to have a major impact on the cost of health insurance.

Meanwhile, the availability of independent review and the possibility of damage suits might motivate MCOs to approve care in marginal cases. Admittedly, given the small number of people who pursue independent review, a cost-conscious MCO manager might rationally decide to preserve stringent standards for approving care. However, the same incentive holds under the current scheme, if not more so, in light of limited liability. Hence, cost alone would not override the need for a federal patients' bill of rights. Insurance plans' concerns over their ability to apply uniform national standards presents a more compelling challenge, but as mentioned, state experimentation will help determine what uniform standards would be fair and effective, both for patients and plans.

The Senate proposal allows for such experimentation without hurting patients. Consider what could have happened with Corcoran and Pappas if the ERISA revisions proposed by the House or the Senate were in effect. Under the House's new version of section 502, Corcoran could have brought a claim in either federal or state court alleging that the MCO violated federal law by negligently denying coverage. If the external reviewer had determined that the recommended care was not medically necessary, Corcoran would have borne the heavy burden of proving the judgment wrong by clear and convincing evidence. In her case, the external reviewer found that the recommended care was medically necessary, so Corcoran might have met this heavy burden. However, the plan could still have prevailed simply by showing, by a preponderance of the evidence, that the external reviewer was wrong. Moreover, Corcoran's biggest problem would have been to show that the MCO's denial of the recommended hospitalization was *the* proximate cause of her injury. In the twentieth century, we came to appreciate that the search for *the* proximate cause of most phenomena is both illusive, and, in the liability context, designed to protect defendants. The MCO would have been correct in asserting that many causes contributed to the tragic loss of Corcoran's

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<sup>187</sup> Jean P. Hearne & Hinda Ripps Chaikind, *Patient Protection and Managed Care: Legislation in the 107th Congress* (Congressional Research Service).

<sup>188</sup> See *supra* notes 143-47 and accompanying text.

baby. Yet, Corcoran needed extraordinary care precisely because of her high-risk pregnancy. Under the Senate bill, patients like Corcoran may or may not have a cause of action under section 502 because their claims involve a “medically reviewable decision” that the bill leaves to state common law, which is notoriously diverse. Nevertheless, this fate seems preferable to the House’s proximate cause standard, which would ensure that few if any ERISA plan beneficiaries will ever establish liability.

Likewise, Pappas would have faced greater difficulties under the House bill. The House version only authorizes a federal cause of action for negligent *denial* of treatment. Pappas was never denied treatment. Under the Senate bill, the devastating delay he was subjected to was a “medically reviewable decision” for which he could have sued in state court.

In sum, while it permits state experimentation that could benefit both plans and beneficiaries, the Senate patients’ bill of rights affords true patient protections. First, it restricts ERISA preemption, allowing all plan participants to invoke ordinary state negligence principles for injuries resulting from “medically reviewable decisions.” Second, it provides a federal remedy for serious bad faith refusals to settle. By contrast, the House version, far from protecting patients’ rights, takes them away. While acknowledging the value of independent review, the House bill so restricts the remedies available that it subverts state external review protections that have been affirmed, at least for independently insured people, by *Moran*. If the Supreme Court’s decision in *Pegram* allows patients to seek redress in state court for medical decisions that result in injury, with the full range of traditional state remedies and ordinary standards of negligence and causation, the House bill effectively reverses the Supreme Court and reasserts managed care’s bubble of immunity for wrongdoing.